Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THOMAS DILGER

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-14-1022-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
December 04, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 12/6/12. Despite multiple attempts to collect on this claim, the insurance carrier is attempting theft of services rendered. The DDE & claim were faxed to the carrier on 12/11/12. Therefore, MDR is filed via certified mail with receipt."

Amount in Dispute: $650.00 + interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider submitted this Request for Medical Fee Dispute Resolution with documentation to support reimbursement for the services at issue. The Carrier has reviewed the documentation and determined that the Provider is entitled to reimbursement for the disputed services. The Carrier is issuing reimbursement in accordance with the adopted Division fee schedule. With the reimbursement being issued, the Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 06, 2012	CPT Code 99456-WP-W5 (Maximum medical improvement and Impairment Rating)	$650.00 + interest	$21.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.130 sets outs the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out the procedures for Medical Payments and Denials.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
5. Texas Labor Code §413.019 sets out the procedures for Interest Earned for Delayed Payments, Refund, Or Overpayment.
6. Texas Labor Code §401.023 sets out the procedures for Interest or Discount Rate.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - No explanation of benefits provided by the requestor

Issues

1. What is the maximum allowable reimbursement for the disputed service in dispute?
2. Is the requestor entitled to interest for the disputed service?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3)(C) states "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." Review of submitted documentation finds the requestor performed maximum medical improvement examination for date of service December 06, 2012. The maximum allowable reimbursement for maximum medical improvement is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(-a-) states "$300 for the first musculoskeletal body area." For reimbursement for the disputed services, the requestor was required to performed impairment rating with full physical evaluation with range of motion. Review of submitted documentation finds the requestor performed impairment rating with full physical evaluation using range of motion to the upper extremity. The allowable for impairment rating with range of motion to the upper extremity is $300.00.

   The total maximum allowable reimbursement is $650.00.

   The requestor provided additional documentation stating partial payment made on December 31, 2013. The respondent provided explanation of benefits detailing payment allowed for the disputed service December 06, 2012.
2. Per 28 Texas Administrative Code §134.130 the requestor is allowed interest in the amount of $21.07 for the disputed service.
3. The division concludes that the allowable for interest is $21.07. The respondent issued payment in the amount of $0.00 for interest. Based upon the documentation submitted, additional reimbursement in the amount of $21.07 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $21.07.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $21.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/20/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

Dispute Resolution Findings and Decision together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.